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Attitudes of California Dermatologists Toward Worker's Compensation

Results of a Survey

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A survey-questionnaire on Worker's Compensation sent to 492 California dermatologists produced 268 replies, a recovery rate of 54 percent, representing approximately 10 percent of the practicing dermatologists in the United States. A total of 75 percent replied they treat Worker's Compensation patients; most of the 25 percent who replied they do not gave strong reasons for refusing to assume the care of these patients. The answers to the questionnaire given by the 201 California dermatologists who treat Worker's Compensation patients are tabulated and discussed. Although there exists considerable misunderstanding among physicians, insurance companies and employers on many aspects of Worker's Compensation, the situation is not without hope for improvement. Better knowledge of work procedures, more availability of precise information on the ingredients of work contactants and cooperation among the interested parties should improve the quality of care for these patients in the future.

DISEASE of the skin continues to be considered the most common occupational disease. Evidence of this is found in statistical reports provided by the California State Department of Public Health. These reports have been published annually since the early 1950's, and are compiled from the "Physician's First Report of Injury or Disease" (Figure 1), which must be completed following the initial visits of patients with possible occupationally-related injury or disease. The informaton that they contain provides a useful glimpse into the extent and variety of occupational skin disease in California (Tables 1 and 2).

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Despite the care with which the Department of Public Health prepares these reports, they fail to reflect accurately the incidence of occupational skin disease in California. Whether the figures for total occurrence are too low or too high is unknown; probably they are too low. For example, the cases of many workers with dermatitis are never recorded because they are treated by plant nurses and no time is lost from work. Some of these workers treat themselves, while others consult physicians who never consider the possibility that the disease might be work-related. On the other hand, in a significant percentage of reported cases the patients are later found to have a skin disease unrelated to employment, but an amended report is never filed. The causative agent that is

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA
AGRICULTURE AND SERVICES AGENCY
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF LABOR STATISTICS AND RESEARCH
P. O. Box 965, San Francisco, Calif. 94101

Immediately after first examination mail one copy **directly** to the Division of Labor Statistics and Research. Failure to file a report with the Division is a misdemeanor. (Labor Code Section 6413.5) Answer all questions fully.

A. INSURANCE CARRIER .....

Do not write in this space

1. **EMPLOYER** .....
2. Address (No., St. & City) .....
3. Business (Manufacturing shoes, building construction, retailing men's clothes, etc.) .....

4. **EMPLOYEE** (First name, middle initial, last name) ..... Soc. Sec. No. .....
5. Address (No., St. & City) .....
6. Occupation ..... Age ..... Sex .....
7. Date injured ..... Hour ..... M. Date last worked .....
8. Injured at (No., St. & City) ..... County .....
9. Date of your first examination ..... Hour ..... M. Who engaged your services? .....
10. Name other doctors who treated employee for this injury .....

11. **ACCIDENT OR EXPOSURE:** Did employee notify employer of this injury? ..... Employee's statement of cause of injury or illness:

12. **NATURE AND EXTENT OF INJURY OR DISEASE** (Include all objective findings, subjective complaints, and diagnoses. If occupational disease state date of onset, occupational history, and exposures.)

13. X-rays: By whom taken? (State if none) .....
Findings:

14. Treatment:

15. Kind of case (Office, home or hospital) ..... If hospitalized, date ..... Estimated stay .....
Name and address of hospital .....
16. Further treatment (Estimated frequency and duration) .....
17. Estimated period of disability for: Regular work ..... Modified work .....
18. Describe any permanent disability or disfigurement expected (State if none) .....
19. If death ensued, give date .....

20. **REMARKS** (Note any pre-existing injuries or diseases, need for special examination or laboratory tests, other pertinent information.)

Name ..... (Type or print) Degree ..... { PERSONAL SIGNATURE OF DOCTOR } .....

Date of report ..... Address (No., St. & City) .....

FORM 5021 (REV. 1) *Use reverse side if more space required* D OSP

Figure 1.—Doctor's First Report of Occupational Injury or Illness (Reproduced by permission of State of California Department of Industrial Relations, Division of Labor Statistics and Research).

recorded on the First Report is often the worker's opinion only; after further investigation, a quite different causative agent may be found.

In a recent study of occupational disease in small businesses in Washington and Oregon, conducted by the University of Washington for the National Institute for Occupational Safety and Health, it was discovered that of 346 conditions of probable occupational origin, only 18 percent were skin disease, which trailed behind hearing loss (28 percent), and respiratory conditions (25 percent). On the other hand, almost 90 percent of the job-related health problems were not reported as occupational disease either on worker's compensation claims or on records kept by employers for the Occupational Safety and Health Administration.[1]

The Worker's Compensation Law in California was enacted in 1913, and since then most physicians have supported and cooperated with its provisions, although often with reluctance. Primary care physicians, such as family physicians, surgeons and internists, treat most of the patients with skin disease, while dermatologists are usually referred more difficult cases, evaluate disputed claims and carry out most of the investigative procedures such as patch testing and plant inspections.

TABLE 1.—*Reports of Occupational Skin Disease, California, 1973*

Total cases	15,671
No time lost	10,474
Time lost	2,788
1-7 days	2,001
8-14 days	435
15 and over	231
Indefinite	121
Not stated	2,409

TABLE 2.—*Occupational Skin Disease Causal Agent, California, 1973*

	Cases
1. Poison oak	3,637
2. Water, soaps, detergents and other cleaning agents	982
3. Solvents	880
4. Plastics	792
5. Petroleum products, not used as solvents	603
6. Glass dust	572
7. Agricultural chemicals	428
8. Acids	426
9. Plant and animal products	391
10. Fruits, nuts, vegetables	382
11. Unspecified dust	258
12. Metals and compounds (other than chromium)	220
13. Food products (other than 10)	210
14. Cement, mortar, plaster	207
15. Cutting oils	206
16. Paints	180
17. Glues, pastes, adhesives	175
18. Medicines, and disinfectants	151
19. Caustics	102
20. Heat, cold, humidity, and other environmentals	98
21. Infections	64
22. Chromium	58
23. Ionizing and other radiation	1
24. Other and unspecified	2,731

In order to learn more about the current attitudes of California dermatologists toward Worker's Compensation, in the fall of 1974 a questionnaire was sent to 492 dermatologists, representing the Fellows and Associates of the American Academy of Dermatology who list their practices in California. It was hoped these practicing dermatologist would share their opinions regarding Worker's Compensation Law, as well as the many and diverse problems presented by patients, insurance companies and employers. By February 1, 1975, 268 replies were received, a rate of recovery of 54 percent. With 2,944 dermatologists listed in private practice in the United States in 1972, the respondents comprise approximately 9 percent of the total number of practicing dermatologists in the United States.

The questions and a tabulation of replies and discussion follow.

1. *Do you treat worker's compensation patients?*
Yes: 201 (75 percent); No: 67 (25 percent)

2. *If not, why not?*

A total of 25 (9 percent) replied negatively because of type of practice (academic, hospital, military or clinic practice). Several respondents had retired and were no longer in practice. Those dermatologists in full-time hospital or military practice undoubtedly treat patients with occupationally-related skin disease, but fail to consider work relationship important.

In all, 42 (15 percent) stated they do not treat worker's compensation cases because they object to one or more features of the practice. Thirteen stated the fee schedule was too low; eleven claimed the paper work excessive; five wrote of "hassles" involved, and four decried "troublesome patients" and "conflicts of interest." Three stated they were never referred these patients, and six gave no reasons. It seems likely that most of the remaining 224 dermatologists who failed to return the questionnaire share several of the above views.

3. *If so, approximately how many new and presumed worker's compensation patients do you see each week?*

1 to 5: 148 (74 percent); 5 to 10: 6 (3 percent); greater than 10: 1 (0.5 percent)

Forty-six (22.5 percent) added another category, suggesting they actually see less than one per week.

4. *How many of the above turn out to be nonoccupational?*

Under 24 percent: 101 (50 percent); 25 to 50 percent: 68 (34 percent); over 50 percent: 18 (9 percent)

No answer: 14 (7 percent)

These figures probably reflect the prevailing opinion among dermatologists that approximately 25 percent of patients who initially are thought to have occupational skin disease are later found to have conditions unrelated to their occupation. It is unlikely that any of the physicians actually reviewed or tabulated their records before answering this question.

5. *Please check (in order of frequency) the industrial sources of your worker's compensation patients:*

Manufacturing	First
Services	Second
Construction	Third
Agriculture	Fourth
Health	Fifth

No answer: 14

Although agriculture is California's principal industry, dermatologists place it fourth as a source of occupational skin disease. This may be explained by the fact that most dermatologists have urban rather than rural practices.

6. *What is the most common occupational skin disease you see?*

All but one respondent stated contact dermatitis, irritant dermatitis, dermatitis venenata, poison oak, or a variation. One physician stated chronic paronychia to be the most common occupational skin condition in his practice.

Fourteen specified one or more of the following: cement, chromates, cutting oils, degreasers, epoxies and other resins, hydrofluoric acid, formalin, color developers, irritation leading to psoriasis, and even strawberries.

7. *What percentage of your worker's compensation cases are the following:*

(1) Contact dermatitis due to irritation? >50 percent: 124; <50 percent: 61

(2) Contact dermatitis due to allergic sensitization? >50 percent: 58; <50 percent: 128

(3) Other skin conditions? (infections, granulomas, tumors and so on) >25 percent: 18; <25 percen: 116

8. *Do you patch test your patients with occupationally-related dermatitis?*

Yes: 186 (93 percent); No: 11 (5 percent); No answer: 4 (2 percent)

This latter question produced the largest number of affirmative answers, indicating a widespread interest in the patch test as a diagnostic tool, and probably represents a significant increase in interest over that prevailing 15 to 20 years ago. The greater emphasis placed on contact dermatitis in dermatology teaching institutions, in journals of dermatology and allergy, at medical meetings and by organizations such as the North American Dermatitis Research Group undoubtedly largely is responsible for the growing number of dermatologists who regularly use patch testing in their practices.

9. *If so, what percentage?*

Over 50 percent: 111 (55 percent); under 50 percent: 50 (25 percent); no answer: 40 (20 percent)

The large percentage of patients patch tested represents those suspected of allergic contact dermatitis rather than irritant dermatitis, which is not investigated by patch testing. The question, however, was not as clear as it should have been.

10. *Do you use any of the following patch test materials:*

Hollister-Stier	58
Johnson and Johnson	24
Combination of above	46
Trolle-Lassen	9
A combination of above	27
Work materials only	5
None	14
No answer	18

Only 9 respondents state they use the patch test materials from the Trolle-Lassen Laboratory in Denmark, which has the most complete selection of patch test chemicals available anywhere.

11. *Are you satisfied that patch testing provides you with useful information in the handling of worker's compensation patients?*

Yes: 146 (73 percent); No: 42 (21 percent); No answer: 13 (6 percent)

12. *If not, why not?*

The dermatologists who answered this question gave a variety of reasons for their dissatisfaction with patch testing. The most common were (1) difficulty in correlation of positive results with the work carried out; (2) suspicion of false negative reactions; (3) inability to duplicate actual work conditions during testing; (4) irritant reactions when testing with substances as used in the work; (5) problems of dilution; (6) spoilage of test materials.

13. *How could patch testing be made more practical in your practice?*

Many of those who answered this question desired a greater range of test materials available, with more accurate information on where they are found, especially ingredients of trade-named products. Several wanted more educational materials, and a number suggested the establishment of "patch test banks" in medical schools where patients could be referred for more detailed study.

14. *What could the employer and/or worker's compensation carriers do to further assist you in the care and rehabilitation of these cases?*

Most of the respondents wanted a more realistic fee schedule, better cooperation between physician and insurance personnel, additional and more detailed information on working techniques and the chemical components of their patient's work contactants. Many dermatologists complained that when dermatitis develops, employers transfer workers to lower-paying positions, or summarily discharge them.

15. *In your opinion, is the incidence of occupational disease becoming:*

(1) More frequent: 25 (12 percent); (2) Less fre-

quent: 23 (11.5 percent); (3) Staying the same: 130 (65 percent); No answer: 23 (11.5 percent)

16. *Do you regularly treat patients referred from any particular plant or factory?*

Yes: 74 (37 percent); No: 119 (59 percent); No answer: 8 (4 percent)

17. *Are you a "panel" physician?*

Yes: 30 (15 percent); No: 143 (71 percent); No answer: 28 (14 percent)

18. *Please check the size of the community or metropolitan area in which you practice:*

Under 10,000: 0; 10,000 to 20,000: 3 (1 percent); 20,000 to 50,000: 28 (14 percent); 50,000 to 100,000: 44 (22 percent); Over 100,000: 110 (55 percent); No answer: 16 (8 percent)

With 82 percent of the respondents practicing in communities of 50,000 persons or more, it appears that dermatologists, along with other physicians, prefer to practice in urban areas.

19. *Are you satisfied with the fee schedule for worker's compensation cases?*

Yes: 89 (44 percent); No: 90 (45 percent); No answer: 22 (11 percent)

20. *Any further comments, please:*

64 did (32 percent)

Most of the comments were a variation or a reemphasis of answers given to question 14.

21. *Signature:*

142 did; 59 did not

Discussion

Physicians who object most strongly to "third party" interference in patient care are often those who find worker's compensation cases the most odious. However, Worker's Compensation Law goes a step further, and adds a "fourth party" with whom physicians must frequently contend: the employer. The necessity to deal with both insurance companies and employers, lower-than-standard fees, extra paper work and occasionally uncooperative or hostile patients, creates an intolerable combination for many physicians.

The situation is not hopeless, which the results of the survey seem to indicate. More than half of those dermatologists who were sent questionnaires responded (54 percent), which in itself indicates a definite stand one way or another. Of those who did take the time to answer, 75 percent stated they do treat worker's compensation patients, and many offered positive, constructive recommendations.

Physicians who complain about the interference of insurance companies and employers should understand that the patient-physician relationship is not entirely private under worker's compensation law. Insurance carriers and employers both have understandable legal rights in the matter. Soon after each occurrence, the insurance company *must* receive from the attending physician information regarding the diagnosis; the nature and extent of anticipated, temporary and permanent disability, and the plan of treatment. Without this information, the underwriter cannot build a cost-projection for that injury or disease and begin rehabilitation efforts when necessary. The insurance company also has legitimate interest in the quality of the care and its cost, and when dissatisfied with the care, may recommend that the patient change physicians. It also has the legal right to demand prompt reports; a frequent complaint of insurance personnel is the slowness with which many physicians submit their reports. On the other hand, physicians justifiably complain about the tardiness with which many carriers process and pay undisputed claims. It is often found that a claim is simply "shelved" because of incomplete information which a telephone call could help resolve.

Because fees vary so widely, "usual and customary" fees are obviously impractical when insurance carriers must plan for future losses. Although there is no doubt that for years worker's compensation fees lagged behind the average physician's charges, the new rate schedule which became effective October 1, 1974 was quite close to the fees charged by most dermatologists in metropolitan areas of California at that time. Physicians often forget, however, that the fees are based upon a minimum fee schedule and insurance carriers will pay any reasonable fee which can be justified by the circumstances. For example, if extra time is required, the insurance carrier will reimburse the physician, but he must show the extra service on the Relative Value Studies (RVS) code, and a narrative report will usually be required. If the patient is referred from another physician, the visit may be considered a consultation. For patch testing, an office visit plus the usual RVS charges for patch testing may be used. Even plant visits are compensable, if requested by the company or insurance carrier, and *prior* authorization is obtained. Such visits are especially valuable to the insurance carrier if the physician's report leads to a safer environment within the plant and fewer claims. Even the services of an industrial hygienist may be made available if they are requested by the carrier.

Excessive paperwork is a frequent complaint. Duplicate copies of the "Physician's First Report" or a more detailed report are legally required to be submitted, immediately following the initial visit, to insurance carrier and the Division of Industrial Safety. As a courtesy, the physician may send a copy to the employer. For subsequent visits, brief supplementary reports must also be filed. The "Physician's First Report" is simple and brief (Figure 1), and contains only basic information. The space provided for description of the work and the nature of the illness is inadequate. For this reason many dermatologists attach a separate report in which the work is described in detail, as well as the substances contacted, the history of the dermatitis, the results of special tests, diagnosis, prognosis, disability and recommendations for treatment and prevention. This provides much more useful information for the insurance company and employer than that contained in the "First Report." If a work relationship is uncertain at the first visit, the dermatologist should state this and suggest the measures necessary to reach a definite decision. Carriers will pay for such investigation until a diagnosis can be reached. If the patient is disabled and the carrier refuses to acknowledge liability, disability payments can be paid from state disability funds and a lien established against the worker's compensation carrier until the case is decided one way or the other, as in disputed cases by the Appeals Board referee.

The "fourth party," the employer, pays the premiums for coverage as required by law, and at a rate determined by his worker's compensation accident and illness experience during the previous year. This method of rate determination was instituted many years ago and emphasizes to the employer the necessity of maintaining safe working conditions and of educating workers in the proper handling of hazardous substances. If a copy of the "Physician's First Report" is sent to the employer, it should state not only the nature of the dermatitis, but also a description of the contributing factors. With this information the employer can consider removal of hazardous materials from contact with workers' skin (through changes in the work processes or techniques of handling) or at least mitigation of the irritating or sensitizing effects through protective measures.

Since enactment of the Occupational Safety and Health Act in 1970, employers have been more cooperative with physicians in providing information regarding plant operations and the ingredients of industrial products. Dermatologists who treat even an occasional patient from a particular plant should arrange to visit the plant, inspect the work areas and discuss the skin hazards with the personnel. Such visits rarely take more than an hour or two, but they can provide a physician with invaluable insight into the activities and hazards of a plant, as well as enabling him to better evaluate future patients' descriptions of their work.

A frequent suggestion is that patch test materials for all industrial contactants should be readily available and inexpensive. A bank of test substances for each of the 35,550 job titles in 21,741 separate occupations[1] cannot be accomplished, for obvious reasons. Thousands of chemicals are used in industry, but only several hundred are definitely known to be contact allergic sensitizers. Many of them are disguised under a trademark, often in combination with other ingredients. It is a formidable and discouraging task confronting the physician who attempts to learn the exact ingredients of industrial products. Persistence and devotion are required; few dermatologists have the time or interest to follow the investigation to completion. However, several texts are available[3-9] to assist dermatologists in learning the ingredients of industrial products. The local Poison Control Center can be immeasurably helpful, not only in providing information on ingredients, but also in supplying telephone numbers of manufacturers, including the names of key persons to contact. The text *Toxicology of Commercial Products* by Gleason, Goslin, Hodge and Smith[9] contains much useful information on ingredients and should be owned by every dermatologist who does patch testing. The local health department, especially if there is a division of occupational health, can be of great assistance, particularly in finding out the previous dermatitis experience of a particular plant or industry, in obtaining information about industrial processes and the ingredients of products, and in helping to develop rapport with the personnel of local industries. Until recently, a copy of each "Physician's First Report" was sent to the occupational health personnel of the county in which the event occurred, keeping these personnel informed of the work hazards of industries in their area, and providing an opportunity for prevention of similar occurrences. Unfortunately this practice was discontinued in 1974, because of lack of funds.

A frequent complaint is that employers simply

discharge workers who must change their jobs because of a disabling dermatitis. If the worker's illness does not require him to leave work entirely, too often he must accept another job at greatly reduced income. Employers in small plants especially, have no choice other than to discharge workers with recurring dermatitis, but California's new rehabilitation law, Assembly Bill 760, enacted on January 1, 1975, may correct some of the inequities, especially if it is properly funded and implemented. Dermatologists can be of immeasurable assistance in the rehabilitation of disabled workers, not only by indicating its necessity but by discussing job alternatives with employers and insurance carrier representatives, and also, in the case of allergic sensitization, clearly stating the permissible occupations in which contact with the patient's sensitizers is unlikely to occur.

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Minidose Heparin Prophylaxis for Prevention of Pulmonary Embolism

The simplest and the most generally applicable method of prophylaxis (before surgical operation) involves drug treatment with various agents designed to prevent hypercoagulability. Agents that have been tested . . . include low dose heparin. In a large series of studies on low dose, preoperative, perioperative and postoperative heparin therapy, in almost all cases a significant protection against peripheral venous thrombosis has been shown. Since venous thrombosis might develop during the day of operation, and one day thereafter, treatment must begin before the operative procedure. In spite of this, bleeding has not been reported as a problem. The standard minidose or small dose heparin prophylaxis is 5,000 units two times a day. . . . Published evidence and clinical experience now indicate that low dose heparin prophylaxis be recommended as primary prevention for all adults in whom major abdominal, pelvic or thoracic surgical procedures are carried out. . . . A standard regimen fulfills most of the criteria demanded of an ideal prophylactic agent. It is well tolerated by the patient, it is free of side effects and it requires no monitoring other than seeing that the patient receives the drug appropriately. It does not produce excessive bleeding when the patient is subjected to major tissue trauma.

Now, I can agree in general with these observations, but with some qualifications. First of all, I am not entirely satisfied that the bleeding problem has been looked at in as much depth as it should be, particularly in terms of morbidity—like late wound complications and actual surgical blood loss. Most of the reported lack of bleeding difficulty is based on observations by the surgeons which are not necessarily quantitative. On the other hand, it is now possible to identify very high risk groups, and I think the data now are so hard that certainly in patients who fall into a high risk group, minidose heparin prophylaxis should be used on the basis of the current knowledge.

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